

DAVID C. HALL, M.D.,
Child, Adolescent and Family Psychiatry

1019 21st Street, Anacortes, WA 98221 ♦ Office (360)588-9470 ♦ FAX (360)299-4372 ♦ Pager (206)998-4702

**PATIENT INFORMATION and
TREATMENT AGREEMENT
(Adult)**

DX:

Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Marital Status: Single Married Remarried Divorced Widowed Partnered Partner's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Work Telephone: (____) _____ Soc Sec # _____

Employer: _____ Occupation: _____

Partner's Employer: _____ Work Telephone: (____) _____ Soc Sec # _____

List of any medications taking currently: _____

Allergies to medication: Yes [] _____ None [] _____

Do you want insurance billed? _____ If so, please fill in insurance info. Is this self-pay? _____

DOES YOUR INSURANCE REQUIRE REFERRAL TO DR. HALL? YES ___ NO ___ (initial)

IS THAT REFERRAL IN PLACE FOR YOUR FIRST VISIT? YES ___ NO ___ (initial)

Who referred you to Dr. Hall? _____ Phone Number: _____

Primary Insurance

Secondary Insurance

Name of Insured:	Relation to Patient:	Name of Insured:	Relation to Patient:
Employer:	WK Number:	Employer:	WK Number:
Insurance Company:		Insurance Company:	
ID/SS Number:	Group Number:	ID/SS Number:	Group Number:

PERSON TO CALL IN CASE OF EMERGENCY:

Name:	Address:	Phone:	Relationship:
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If you should have a medical emergency, call 911. If you need to reach me URGENTLY, dial 206-998-4702 and at the beep touch in your 10-digit phone number then hang up. If I haven't called you back soon enough, please try again to be sure the page worked.

I understand I am fully responsible for payment for care I receive. Dr. Hall will on occasion negotiate fees with proof of family income.

I understand that 24-hour notice of cancellation is required and that I may be charged \$40 for late cancellation of a 45 minute appointment or \$20 for late cancellation of a 25 minute appointment.

I HEREBY AUTHORIZE Dr. Hall to provide treatment for myself:

Signed: _____ Print your name: _____ Date: _____

I AUTHORIZE Dr. Hall to *EXCHANGE MEDICAL/PSYCHIATRIC INFORMATION* with my primary care physician:

PCP's name: _____ Phone _____

PCP's address: _____ Fax _____

Other person(s) authorized to exchange medical/psychiatric information (spouse, partner, counselor, others):

Name: _____ Contact information: _____

Name: _____ Contact information: _____

Name: _____ Contact information: _____

This authorization remains in effect until (initial one): _____ I rescind it in writing
_____ 90 days from today.

Signed: _____ Print your name: _____ Date: _____

Thank you.

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Intake Questionnaire - Adult
(Complete and bring with you to first appointment)

Date: _____

Patient's name: _____ **Birthdate:** _____ **Sex:** _____

Patient's marital status: **Single** **Married** **Separated** **Divorced** **Widowed** **Remarried** **Partnered**

Partner's name: _____

Parents' names: _____

Your Home address: _____ **Home phone:** _____

Phone: Work _____ **Cell** _____ **Email:** _____

Primary care physician: _____ **Phone:** _____

Education: **High school** **College degree** ____ **Graduate school** ____ **Other** ____

Who lives in the same household with you? _____

Please state briefly the problem(s) you wish Dr. Hall to address and why you seek help at this particular time.

Problem #1 _____

Problem #2 _____

Problem #3 _____

Other Problems _____

Is anyone currently at risk of serious harm? Yes No Please describe:

Past diagnoses or mental health care:

Please write a brief history of each problem above, including when it started, how it developed, what was helpful and what was not, any medications tried, and why you seek help now.

(Use back of this sheet for additional writing space)

Your Developmental History

Pregnancy, birth, and infancy for you was normal and healthy
difficult (please describe):

Toddler years: walked by 14 months clear words by 18 months simple sentences by 2 years
Comment _____

Preschool years: socializes well learns letters & sounds counts to 100 behavior problems
Comment _____

Elementary school years: makes friends easily well-focused in school good physical skills for age
behavior problems school problems
Comment _____

Middle school years: makes friends easily well-focused in school good physical skills for age
behavior problems school problems
Comment _____

High school years: makes friends easily well-focused in school good physical skills for age
behavior problems school problems
Comment _____

Academic strengths: _____

Academic difficulties: _____

Medication history

Medicines you take (include when started, doses, time of day taken):

name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____

Other medicines your child used to take (list them): _____

Allergies to medicine (list all of them)	NONE: [__]
name of medicine: _____	reaction: _____
name of medicine: _____	reaction: _____
name of medicine: _____	reaction: _____
Allergies to food: _____	

Hospitalizations: _____

Surgeries/broken bones: _____

Head injuries: _____

Drug or alcohol use (what, when, how long): _____

Family psychiatric history (mental or emotional problems that run in the family, ie, siblings, parents, aunts, uncles, cousins, grandparents):

Family medical history (medical problems that run in the family, ie, siblings, parents, aunts, uncles, cousins, grandparents):

Related concerns. Do you:

snore or make odd breathing sounds while asleep? Yes No

seem to stop breathing while asleep? Yes No

feel unduly tired or sleepy during the day? Yes No

become excessively anxious? Yes No

become excessively moody, irritable, explosive or depressed? Yes No

have unusual difficulty making and/or keeping friends? Yes No

have compulsive rituals or complain of obsessive thoughts? Yes No

have a problem with alcohol or drugs? Yes No If yes, what substances? _____

have a history of legal difficulties or school expulsions? Yes No

have unusual difficulties with a particular subject in school? Yes No

have unusual difficulties with focus, concentration, or boredom? Yes No

give up easily when faced with schoolwork, sports, or other tasks? Yes No

have a history of emotional, physical, or sexual assault? Yes No

have a history of severe emotional loss? Yes No If yes, what losses _____

have a relative who has killed himself or herself? Yes No If yes, relation to you _____

ever hear voices or see things you know are not there? Yes No Or have strange recurrent thoughts? Yes No

have firearms in the home? Yes No If Yes, are they kept loaded? Yes No Locked? Yes No

Please list prior mental health providers below:

Provider's name: _____ Phone: _____ Fax: _____

Approximate dates of service: _____

Provider's name: _____ Phone: _____ Fax: _____

Approximate dates of service: _____

Provider's name: _____ Phone: _____ Fax: _____

Approximate dates of service: _____

Comments/other information:

Your Treatment Goals (what will be accomplished if treatment is successful):

1) _____

2) _____

3) _____

4) _____

Your signature: _____ Date: _____

If not the patient, your name: _____

Relation to patient: _____ Date: _____

Thank you.